

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7967

## CERTIFICATE OF DEATH

07950

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grantsville, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grantsville, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLEVELAND</b> Middle <b>EDGAR</b> Last <b>ASHBY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>7</b> Days <b>13</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ser Station Operator &amp; store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hutton MD</b>	
11. BIRTHPLACE (State or foreign country) <b>Us. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Us. S.</b>	
13. FATHER'S NAME <b>John T. Ashby</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Schaeffer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-03-7031</b>	
17. INFORMANT Address <b>Mrs Irva Mickey, Grantsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute mypcardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>5 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 6</b> , 19 <b>58</b> , to <b>July 13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 12</b> , 19 <b>59</b> , and that death occurred at <b>9:00 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Grantsville, Md.</b> DATE SIGNED <b>7/14/59</b>			
ACTUAL SIGNATURE <b>A. Paige Strong</b> M.D.		PHYSICIAN'S NAME (Type) <b>A. Paige Strong</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grantsville, Grantsville, Garrett Co., Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J. Newman</b> ADDRESS <b>Grantsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00000

MISSISSIPPI STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

CERTIFICATE OF DEATH

2000

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>		<p>9. CAUSE OF DEATH [Faint text]</p>	
<p>10. MEDICAL HISTORY [Faint text]</p>		<p>11. PRESENT ILLNESS [Faint text]</p>		<p>12. MANNER OF DEATH [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>		<p>15. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>16. SIGNATURE OF CORONER [Faint text]</p>		<p>17. SIGNATURE OF JURY [Faint text]</p>		<p>18. SIGNATURE OF JUDGE [Faint text]</p>	
<p>19. SIGNATURE OF CLERK [Faint text]</p>		<p>20. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>21. SIGNATURE OF ASSISTANT REGISTRAR [Faint text]</p>	

THE QUALITY OF THE RECORDS OF THE MISSISSIPPI STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS IS GUARANTEED BY THE MISSISSIPPI STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS.

7968

## CERTIFICATE OF DEATH

Reg. Dist. No.

07951

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Mt. Lake Park,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-----</b>				d. STREET ADDRESS <b>1 -----</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Myrtle Gower Bittinger</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>12,</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 27, 1893</b>	<b>9. AGE (In years last birthday)</b> <b>65</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>-----</b> Days <b>-----</b>	<b>IF UNDER 24 HRS.</b> Hours <b>-----</b> Min. <b>-----</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Jacob Henry Gower</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia Ann Lower</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>-----</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT</b> <b>Ray E. Bittinger</b> Address <b>Mt. Lake Park, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Heart Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Arteriosclerosis</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 year</b> <b>5 years</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>9/12/</b> , 19 <b>40</b> , <b>to</b> <b>7/12/</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/11/59</b> , 19 <b>59</b> , and that death occurred at <b>2:30A</b> M, from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>Oakland Md</b> <b>DATE SIGNED</b> <b>13 July 59</b>							
<b>ACTUAL SIGNATURE</b> <b>Andrew E. Mance</b> M.D.		<b>PHYSICIAN'S NAME (Type)</b> <b>Andrew E. Mance, M.D.</b> <b>Oakland, Md.</b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>7/14/1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Oakland Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Oakland, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. C. Leighton</b> ADDRESS <b>Oakland, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 22 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles E. Thomas</b>	

VS A15 (4)  
15M 10/57

VS A15 (4)  
15M 10/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7969 CERTIFICATE OF DEATH

Reg. Dist. No.

07952

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>8 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Crellin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>Box #117</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Polyard</u> Last <u>Polyard</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>59</u>	IF UNDER 24 HRS. Months <u>3</u> Days <u>19</u> Hours <u>59</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John M. Polyard</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hershman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Nora Polyard, Box #117, Crellin, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident, left</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brain - Pneumonia</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>2 1/2 hrs</u> <u>7 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>o. m.</u> Month, Day, Year <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 56</u> , 19 <u>57</u> , to <u>7-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>59</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>582-1st Oakland Md</u> DATE SIGNED <u>7-3-59</u>							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D. <u>582-1st Oakland Md</u>							
PHYSICIAN'S NAME (Type) <u>James H. Feaster, Jr.</u> M.D. <u>Oakland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Israel Cemetery</u>		22d. LOCATION (City, town, county, state) <u>near Fellowsville, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

50000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

CERTIFICATE OF DEATH

1962

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

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IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07953									
1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 40, Long Stretch, F'bg.</b>					c. LENGTH OF STAY IN 1b <b>X</b> <b>Avilton</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>1</b>				
3. NAME OF DECEASED (Type or print) First <b>BONNIE</b> Middle <b>LEE</b> Last <b>BROADWATER</b>					4. DATE OF DEATH Month <b>7</b> Day <b>13</b> Year <b>19 59</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 15th, 1951</b>		9. AGE (In years last birthday) <b>8</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Roy Broadwater</b>					14. MOTHER'S MAIDEN NAME <b>Diona Crowe</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Roy Broadwater, Avilton, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured SKULL</b> <b>812X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Broken Neck</b> DUE TO (c) <b>TTTUIT P/E Contusions</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by automobile when crossing road, Rt. 40 6 mi. west of Frostburg, Maryland</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>4</b> a.m. <b>713</b> p.m. <b>19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 40 Street</b>		20f. (City or town) <b>Rural Frostburg</b>		20g. (County) <b>Garrett</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John W. Feaster</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>J. H. Feaster, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-16-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) <b>Garrett County, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>					24a. REC'D BY REGISTRAR <b>JUL 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		

TO DEPUTY MEDICAL EXAMINER:

VS. A15ME  
SM 2/57

Certificate should be executed within 24 hours after death. If a delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

07303

MARYLAND STATE DEPARTMENT OF HEALTH - CARROLL IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7073

Deceased

Married

Single

Deceased

Age 70

John Brown, Jr.

Sex

Male

White

None

Married

John Brown

John Brown

John Brown, Jr.

Causes of death

Heart disease

Diagnosis

Signature

Witness

John Brown, Jr.

John Brown, Jr.



7971

## CERTIFICATE OF DEATH

Reg. Dist. No.

07954

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b>		c. LENGTH OF STAY IN 1b <b>25 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Rural Deer Park</b>		d. STREET ADDRESS <b>R. D. 1 mi. West</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. one mile west Deer Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Hugh</b> Last <b>Campbell</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Track worker, Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Malinda Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-01-8804</b>	
17. INFORMANT <b>Mrs. Dora Campbell</b>		Address <b>Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Aneurysm</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchial Asthma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1956</b> to <b>July 27, 1959</b> , that I last saw the deceased alive on <b>July 27, 1959</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph Calandrella</b>		DATE SIGNED <b>July 31-59</b>	
PHYSICIAN'S NAME (Type) <b>Ralph Calandrella, M.D.</b>		<b>Kitzwiller, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/30/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Deer Park, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU OF VITAL RECORDS

WILLIAM BOND

Name of Deceased		Date of Birth		Sex		Race		Place of Birth		Date of Death		Time of Death		Place of Death	
WILLIAM BOND		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Education		Marital Status		Religion	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer		Signature of Cemetery		Signature of Funeral Home	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7972

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07955

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accident R.D.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DIANA</u> Middle <u>ELAINE</u> Last <u>DURST</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1956</u>		9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edison Durst</u>				14. MOTHER'S MAIDEN NAME <u>Lula Bittinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Lula Durst, Accident, R.d. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>830X</u> <u>fractured skull</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran over by farm tractor on own farm</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7-23</u> 19 <u>59</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) (County) (State) <u>Grantsville Garrett Co. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				DATE SIGNED <u>7-23-59</u>			
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don G. Horman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7973 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07956**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Garrett</b></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Accident</b>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Working in woods So. Accident</b>						d. STREET ADDRESS <b>2 Mi. S.E. Deer Park</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Lawrence</b> Middle <b>Clifton</b> Last <b>Ervin</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>21,</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 29, 1918</b>		<b>9. AGE</b> (In years last birthday) <b>40</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer, cutting trees in woods</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Coy Webster Ervin</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Bessie Paugh</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>219-01-8605</b>		<b>17. INFORMANT</b> <b>Victor Ervin</b>				Address <b>Deer Park, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Fractured Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>While cutting a tree down, another tree fell and struck pt. on head,</b>									
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>12:45 p.m. 7-21-1959</b>				<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		<b>20f. (City or town)</b> <b>Rural Accident Garr. Md.</b>		(County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <i>James H. Feaster, Jr.</i>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>7-21-59</b>							
<b>EXAMINER'S NAME (Type)</b> <b>James H. Feaster, Jr., M. D.</b>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>7/23/1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Paugh Cemetery</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>2 Mi. S.E. Deer Park, Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>H. S. Leighton</i>						ADDRESS <b>Oakland, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUL 27 59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>W. H. S. Frank</i>			

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7974

## CERTIFICATE OF DEATH

07957

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			c. LENGTH OF STAY IN 1b <u>3 weeks</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X (Rural) Oakland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Clement</u> Last <u>Foley</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/25/1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>59</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Gortner, Maryland</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>John Foley</u>				14. MOTHER'S MAIDEN NAME <u>Annie Meckim</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-12-9250</u>		17. INFORMANT <u>Mrs. John Foley, Rt. #2, Oakland, Maryland</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial heart disease &amp; hypertrophy</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>failure</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 9, 1945</u> to <u>July 10, 1959</u> , that I lost saw the deceased olive on <u>July 10, 1959</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Mance</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland Md</u>		DATE SIGNED <u>11 July 59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. A. E. Mance</u>				<u>Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Leighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Mance</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7975

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN 1b <b>6 1/2 Hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Kitzmiller</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>4 Mi. N. Kitzmiller</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William Stanley</b> Middle <b>Harvey</b> Last <b>Harvey</b>				4. DATE OF DEATH Month <b>July</b> Day <b>14,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1909</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer &amp; School Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William W. Harvey</b>				14. MOTHER'S MAIDEN NAME <b>Birdie Blanche Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-2952</b>		17. INFORMANT Address <b>Mrs. Arvella Harvey R.D. Kitzmiller, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopericardium</b> <b>451X</b> DUE TO (b) <b>Ruptured Dissecting aneurysm of aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elk Garden, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A.C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the words "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7976

## CERTIFICATE OF DEATH

07959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural McHenry,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuppitt Nursing Home</b>		d. STREET ADDRESS <b>Sang Run Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>H.</b> Last <b>Hawkins</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Marion Hawkins</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Eddy</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <b>Eldie Piggot</b> Address <b>Enterprise, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Lymphatic Leukemia</b> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>April</b> , 19 <b>59</b> , to <b>June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 25</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.</b> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland, Md.</b> DATE SIGNED <b>7/3/59</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/6/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>near McHenry, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.C. Leighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7977

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07960

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Lonaconing, Md.</u>		c. LENGTH OF STAY IN 1b <u>19 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Lonaconing, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>ELIZABETH</u> Last <u>HETZ</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1870</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Wilhelm</u>				14. MOTHER'S MAIDEN NAME <u>Ellen McKenzie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Thomas Hetz, RFD, Lonaconing, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Foster, Jr., M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James H. Foster, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>		22d. LOCATION (City, town, or county) (State) <u>Alvilton, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman</u>				ADDRESS <u>Greentville, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>JUL 7 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

# MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		PLACE OF BIRTH _____	
OCCUPATION _____		MARITAL STATUS _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF DECEASED _____	
ADDRESS OF DECEASED _____		ADDRESS OF EXAMINER _____	
CITY OF DEATH _____		COUNTY OF DEATH _____	
STATE OF DEATH _____		ZIP CODE _____	

ORIGINAL FILED IN



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7978

## CERTIFICATE OF DEATH

Reg. Dist. No.

07961

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>79 ALDER STREET</b>							
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>MC HENRY</b> Last <b>HOWARD</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 29, 1886</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher, in Baltimore</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Charles MC HENRY HOWARD</b>				14. MOTHER'S MAIDEN NAME <b>JULIA ANNA COLEMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>HELEN J. SHOLLY</b> Address <b>79 ALDER STREET, OAKLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis with</b> DUE TO (c) <b>Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Oakland</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>7-7</b> , 19 <b>59</b> , to <b>7-10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-10</b> , 19 <b>59</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>				ADDRESS (Street, city or town, state) <b>582-1 St. Oakland, Md.</b>			
DATE SIGNED <b>7-11-59</b>							
PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR. M.D.</b>				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/11/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Worshipful Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>4905 York Road, Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BROWN

MALE  
WHITE  
BORN

DATE OF DEATH

PLACE OF DEATH

AGE

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF MINISTER

NAME OF CHURCH

NAME OF FUNERAL HOME

NAME OF CARRIER

NAME OF DRIVER

NAME OF PASSENGER

NAME OF ATTENDANT

NAME OF ASSISTANT

NAME OF DRIVER

NAME OF PASSENGER

NAME OF ATTENDANT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7979

## CERTIFICATE OF DEATH

Reg. Dist. No. 07962

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>ESTELLA</b> Last <b>HUMBERSON</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK UMBLE</b>		14. MOTHER'S MAIDEN NAME <b>ELMA LEIGHTY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>EVELYN FRIEND</b>		Address <b>FRIENDSVILLE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Standstill</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anteroseptal Myocardial Infarct</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7-10</b> , 19 <b>59</b> , to <b>7-28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-26-59</b> , 19 <b>59</b> , and that death occurred at <b>10:10</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Pedro Rivera</b>		ADDRESS (Street, city or town, state) <b>Friendsville, Md.</b> DATE SIGNED <b>7/28/59</b>	
PHYSICIAN'S NAME (Type) <b>PEDRO RIVERA, M.D.</b>		<b>FRIENDSVILLE, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>7/29/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Humberston Cemetery near Friendsville, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7980

## CERTIFICATE OF DEATH

Reg. Dist. No.

07963

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>P.O. Bayard, W. Va.</b>			c. LENGTH OF STAY IN 1b <b>22 yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Post Office, Bayard, W. Va.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>across the river from Bayard, W. Va.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Kelley</b>			4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 11, 1886</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George Maust</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Jamison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Hilary E. Kelley Bayard, W. Va.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Hypertrophy &amp; failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>82 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>82 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 Jan. 1959</b> to <b>30 June 1959</b> , that I last saw the deceased alive on <b>30 June 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.				ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>July 5, 59</b>			
PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M.D.</b>				<b>Oakland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near - Gorman, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. C. Leighton</b> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7981

Item# FilmG244 7/13/59 cap  
CERTIFICATE OF DEATH

07964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>9 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Evans Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lavenia Agnes Kreip</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9. AGE (In years last birthday) yrs. <b>81</b>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Hill</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>174X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis with generalized</b> DUE TO <b>retention</b> (c) <b>2 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>58</b> , to <b>July 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 2</b> , 19 <b>59</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Ralph Calandrella</b> M.D. <b>Kitz Miller, Md</b> <b>July 6-59</b> PHYSICIAN'S NAME (Type) <b>Ralph CALANDRELLA</b> <b>Kitz Miller</b> <b>Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>7/6/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 9 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7982

## CERTIFICATE OF DEATH

Reg. Dist. No. 07965

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>PRESTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROWLESBURG</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EVANS NURSING HOME</b>		d. STREET ADDRESS <b>MAIN STREET</b>							
3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>A.</b> Last <b>MAY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>7th</b> Year <b>19 59</b>							
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 23, 1868</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>4</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED OFFICE CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R R Co</b>		11. BIRTHPLACE (State or foreign country) <b>ROWLESBURG WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>LEWIS MAY</b>			14. MOTHER'S MAIDEN NAME <b>MALISSA ROGERS</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-40-9489</b>		INFORMANT <b>Mrs. Mrs. Martha Eliason, Rowlesburg, W.Va.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Coronary Thrombosis: with myocardial infarction.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia, Right Lower Lob.</b> (c) <b>Arteriosclerosis Heart Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>5 days</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1, 1959</b> to <b>July 7, 1959</b> that I last saw the deceased alive on <b>July 5th, 1959</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Aurora, W. Va.</b> DATE SIGNED <b>7-8-59</b>									
ACTUAL SIGNATURE <b>Alfred Owre, Jr. M.D.</b>		PHYSICIAN'S NAME (Type) <b>ALFRED OWRE, M.D.</b>		ADDRESS <b>AURORA WEST VIRGINIA.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>		22b. DATE THEREOF <b>7/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>AURORA CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>AURORA WEST VIRGINIA.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. R. WATSON Md. F.D. A 7220</b>				ADDRESS <b>TERRA ALTA W. VA.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1962

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

JULY

JULY

JULY

1962

1962

WILLIAM

WILLIAM

WILLIAM

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WILLIAM

WILLIAM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7983

## CERTIFICATE OF DEATH

Reg. Dist. No.

07966

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Accident</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SOLOMON</u> Middle <u>ORENDORF</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <u>Former retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Bittinter, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Orendorf</u>				14. MOTHER'S MAIDEN NAME <u>Polly Hochstettler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hugh Orendorf, R.R.D. Accident, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>2 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 20, 1959</u> , to <u>July 4, 1959</u> , that I last saw the deceased alive on <u>July 3, 1959</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph Calondrelle</u>				ADDRESS (Street, city or town, state) <u>Bittinger, Garrett Co., Md.</u>			
PHYSICIAN'S NAME (Type) <u>RALPH CALONDRELLE</u>				DATE SIGNED <u>July 6-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Glade</u>		22d. LOCATION (City, town, or county) (State) <u>Bittinger, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>				ADDRESS <u>Grantsville, Md/</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1953

12000

1. Name of deceased (Print name and last name) JAMES EARL RAY		2. Sex Male	
3. Date of birth May 19, 1928		4. Place of birth Jackson, Tennessee	
5. Date of death April 4, 1968		6. Place of death Memphis, Tennessee	
7. Cause of death (List all causes) Shot - Gun		8. Manner of death (Check one) <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined	
9. Physician (Name and address) Dr. J. Edgar Hoover, FBI, Washington, D.C.		10. Medical examiner (Name and address) Dr. J. Edgar Hoover, FBI, Washington, D.C.	
11. Burial or cremation (Check one) <input checked="" type="checkbox"/> Buried <input type="checkbox"/> Cremated		12. Name of funeral home (If any) None	
13. Name of next of kin (Print name and address) None		14. Signature of declarant (Print name and address) None	
15. Signature of registrar (Print name and address) None		16. Signature of physician (Print name and address) None	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7984

## CERTIFICATE OF DEATH

07967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BABY BOY SINES</b>				4. DATE OF DEATH <b>JULY 28</b> Day Year <b>59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 28, 1959</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>RICHARD SINES</b>		14. MOTHER'S MAIDEN NAME <b>HELEN CATHERINE WHITACRE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HELEN SINES, ROUTE #1, OAKLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.5 Prematurity - 6 mos</b> DUE TO <b>Premature Separation placenta - (maternal)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>761.5</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>53 min.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 July, 1959</b> , to <b>28 July, 1959</b> , that I last saw the deceased alive on <b>28 July, 1959</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland</b> DATE SIGNED <b>29 July 59</b>							
ACTUAL SIGNATURE <b>A. S. Mance</b> M.D.				PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE</b> <b>OAKLAND, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sines Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Swallow Falls Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Minnich Funeral Home Oakland, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Finner</b>	

2070202XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7985

## CERTIFICATE OF DEATH

Reg. Dist. No. 07968

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,		c. LENGTH OF STAY IN 1b 20 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland.		b. COUNTY Garrett		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Deer Park,		d. STREET ADDRESS Route #219		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rex		First Rex		Middle Snyder		Last Snyder		4. DATE OF DEATH Month July 2,		Day 1959		Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1908		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Stone Mason				10b. KIND OF BUSINESS OR INDUSTRY Maryland.				11. BIRTHPLACE (State or foreign country) Maryland.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Peter Snyder						14. MOTHER'S MAIDEN NAME Amanda Arnold									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. W. W. #2				17. INFORMANT Mrs. Rex Snyder				Address R. D. Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X CEREBRAL Vascular Accident, Ant. 4-4-28 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension Comp. Renal disease DUE TO (c) 7 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Cerebral Vascular Accident												INTERVAL BETWEEN ONSET AND DEATH 7-10 minutes 7 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1957, 19 to 6-28, 1959, that I last saw the deceased alive on 6-28, 1959, and that death occurred at 7:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James H. Feaster Jr., M.D. Oakland, Md. 7-5-59															
ACTUAL SIGNATURE James H. Feaster Jr.				PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D.				Oakland, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/5/1959				22c. NAME OF CEMETERY OR CREMATORY Ferndale Cemetery				22d. LOCATION (City, town, or county) (State) near Oakland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE JUL 9 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Travis			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of medical examiner		18. Signature of pathologist		19. Signature of anatomist		20. Signature of histologist	
21. Signature of bacteriologist		22. Signature of virologist		23. Signature of parasitologist		24. Signature of immunologist		25. Signature of epidemiologist	
26. Signature of public health officer		27. Signature of health officer		28. Signature of sanitarian		29. Signature of inspector		30. Signature of auditor	
31. Signature of clerk		32. Signature of stenographer		33. Signature of messenger		34. Signature of janitor		35. Signature of cook	
36. Signature of nurse		37. Signature of pharmacist		38. Signature of dentist		39. Signature of optician		40. Signature of electrician	
41. Signature of plumber		42. Signature of painter		43. Signature of carpenter		44. Signature of mason		45. Signature of bricklayer	
46. Signature of cooper		47. Signature of blacksmith		48. Signature of farrier		49. Signature of harness maker		50. Signature of saddler	
51. Signature of shoemaker		52. Signature of hatter		53. Signature of druggist		54. Signature of optician		55. Signature of oculist	
56. Signature of dentist		57. Signature of veterinarian		58. Signature of farmer		59. Signature of merchant		60. Signature of laborer	
61. Signature of soldier		62. Signature of sailor		63. Signature of stevedore		64. Signature of cooper		65. Signature of cooper	
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1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of coroner

17. Signature of medical examiner

18. Signature of pathologist

19. Signature of anatomist

20. Signature of histologist

21. Signature of bacteriologist

22. Signature of virologist

23. Signature of parasitologist

24. Signature of immunologist

25. Signature of epidemiologist

26. Signature of public health officer

27. Signature of health officer

28. Signature of sanitarian

29. Signature of inspector

30. Signature of auditor

31. Signature of clerk

32. Signature of stenographer

33. Signature of messenger

34. Signature of janitor

35. Signature of cook

36. Signature of nurse

37. Signature of pharmacist

38. Signature of dentist

39. Signature of optician

40. Signature of electrician

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07969

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Garrett</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 135 to Cumberland,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mountain Lake Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On route to Baltimore, Md.</u>				e. STREET ADDRESS <u>----</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ronald</u> Middle <u>Ernest</u> Last <u>Tasker</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>2</u> Year <u>19 59</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>May 15, 1941</u>		<b>9. AGE</b> (In years last birthday) <u>18</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>General Work</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Ernest G. Tasker</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Nellie Lee</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-38-1787</u>		<b>17. INFORMANT</b> Address <u>Mrs. Nellie Tasker Mt. Lake Park, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, BILATERAL, FULMINATING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Notural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>James H. Feaster, Jr.</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <u>JAMES H. FEASTER, JR., M. D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>7-2-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7/5/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Deer Park Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Deer Park, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>H. E. Leighton</u> <u>Oakland, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUL 6 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07970

Reg. Dist. No.

7987

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>13 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MILTON EDWARD TUCKER</b>				4. DATE OF DEATH Month Day Year <b>JULY 15 1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 10, 1894</b>		9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm FARMING</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>DAVID TUCKER</b>			
14. MOTHER'S MAIDEN NAME <b>LAURA RILEY</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>219-03-9257</b>				17. INFORMANT <b>JANE TUCKER, ROUTE #1, BOX #30 S DEER PARK, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-Phrenic Abscess with massive Right Pleural Effusion</b> DUE TO <b>153.8</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Advanced Metastatic Carcinoma</b> DUE TO <b>6 Months</b>							
(c) <b>Carcinoma of the Colon</b> DUE TO <b>12-18 Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous Nephrectomy - Renal Tuberculosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 1959</b> , to <b>July 15, 1959</b> , that I last saw the deceased alive on <b>July 15, 1959</b> , and that death occurred at <b>11:25 P.M.</b> from the causes and on the date stated above.							
22. ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b>							
23. DATE SIGNED <b>16 July 59</b>							
ACTUAL SIGNATURE <b>Herbert H. Leighton, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>HERBERT LEIGHTON, M.D.</b>							
24. OAKLAND, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>7/18/1959</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>White Church Cemetery</b>							
22d. LOCATION (City, town, or county) (State) <b>6 Mi. S. Deer Park, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>							
ADDRESS <b>Oakland, Md.</b>							
24a. REC'D BY REGISTRAR <b>JUL 21 '59</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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